**Medical Assistance Advisory Council (MAAC)**
**IA Health Link Public Comment Recommendations**
**June 27, 2017**

| Recommendation/Referral | Response |
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| Recommendation: The Department is to develop a new methodology to track consistency of prior authorization determinations within each MCO. | Each MCO uses slightly different prior authorization criteria for different types of services. While the IME could perform regular audits of prior authorization decisions, it would be resource intensive to train the auditors for each prior authorization criteria as well as the time and staff needed to perform the audits. MCOs are reviewed on their prior authorization process by third party entities such as the department's external quality review organization as well as the NCQA accreditors. MCOs additionally have processes in place to perform internal quality assurance checks that include inter-rater reliability tests on utilization management staff. |
| Recommendation: The Department is to enforce and communicate to the MCOs the cap after which a prior authorization request is deemed approved (seven days) if a determination has not been made. The MCOs are then to communicate the determination to providers. | The department currently reviews prior authorizations that do not meet the timeliness standard in the contract to ensure that those authorizations are deemed approved. |
| Recommendation: Regarding clearinghouse issues: Request that the MCOs provide data related to the initial denial rates from their clearinghouses and include this data in the Managed Care Quarterly Report. | The department could require the MCOs to report on the number of claims that are rejecting and reasons why at their clearinghouse level. However, if a provider uses a third party clearinghouse, the MCOs would not be able to capture or report this information. Providers are sent rejection reasons from the clearinghouses that they submit their claims to; however, the Managed Care Bureau does not see a clear utility in adding this report. |
| Recommendation: Include the accuracy and consistency of information provided by the MCO Customer Service Representatives to both providers and members in the Managed Care Quarterly Report. | The department could require the MCOs to report on their own quality assurance activities performed on their call centers to include in the Managed Care Quality Report. MCOs are mitigating these issues as they become aware through these quality assurance activities; however, the Managed Care Bureau does not see a clear utility in adding this report. |
| Recommendation: Include secret shopper results to the Managed Care Quarterly Report. | No additional workload would be required to include the secret shopper data in the Managed Care Quarterly Report but the Managed Care Bureau questions whether this would provide useful information to stakeholders. |
| Recommendation: Request that the MCOs report information regarding outreach efforts to increase access to care in areas identified in the MCO's GeoAccess | The MCOs currently report on barriers to network adequacy as part of the network access adequacy exception reports that are |

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| Reports as limited access areas. | submitted to the department for approval. Many of these barriers are due to workforce shortages that are concurrently occurring in Medicaid Fee-for-Service (FFS) as well as the commercial market. Outreach and expansion of workforce should be a joint effort between multiple stakeholders/agencies and not solely the responsibility of the MCOs. |
| Recommendation: Request that MCOs present on results of outreach efforts in order to determine outstanding issues that the MAAC may be able to address. | Managed Care Organizations are able to provide presentations on whatever the MAAC requests and have done so as requested. This should be added to the agenda if the MAAC believes this to be useful. |
| Recommendation: Request summaries of the MCO's Consumer Advisory Panels and Clinical Advisory Panels. Request that MCOs make a periodic formal presentation to the MAAC regarding the timely data and feedback obtained from their required advisory panels. | Managed Care Organizations are able to provide presentations on whatever the MAAC requests and have done so as requested. This should be added to the agenda if the MAAC believes this to be useful. |
| Recommendation: Encourage the MCOs to develop consistent service groups or crosswalk standards for prior authorizations to allow for instances where approval is obtained for a specific service or products. Recommend that each of the MCOs develop an exemption process based on medical necessity. | Standardized prior authorization criteria and crosswalks, as well as an exemption process, is not industry standard and contrary to managed care. The department has worked with the MCOs to provide additional information to stakeholders on service category prior authorization requirements and continues to update that document as necessary. |
| Recommendation: Require the MCOs provide a plain language explanation to Iowa Medicaid members and providers for prior authorization denials. | Plain language explanations of authorization denials and reductions is a federal requirement and monitored on a regular basis as well as part of the MCO external quality review. |
| Recommendation: The Department is to determine the differences in credentialing requirements between the MCOs and develop a comparison grid of what additional measures beyond the IME's universal credentialing is required by each MCO. | The department can work with the MCOs on the differences of credentialing requirements and post to the Medicaid Modernization webpage for stakeholder review. |
| Recommendation: Require the MCOs explain the rationale for additional credentialing requirements beyond what is contractually required by the IME. | The MCOs have requirements above and beyond the requirements of Iowa Medicaid due to NCQA accreditation as well as corporate policy. These rationales could be included in the crosswalk mentioned above as long as proprietary information is not included. |
| Recommendation: Determine the percentage of clean claims payments that are paid on time and accurately based upon the established rate floors to track the accuracy of provider payments. | The department continues to look at a number of data sources to verify accurate payment. Reviewing and reporting accuracy of payment on a systemic basis is outside of industry standards and not possible with a credible level of accuracy due to individualized provider contracts, different copayments and client participation, and lesser of logic applied for billed vs. allowable charges. |
| Recommendation: Encourage the development of a standardized process | Standardized member manuals is a federal requirement that was |

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| across the MCOs to create consistent member material to inform members on what services are provided by each MCO, the process for denying services, and what resources will be given to review available services. | implemented July 1, 2017. The department and MCOs have been actively working towards this standardization. |
| Recommendation: Require the MCOs to provide a plain language explanation to Iowa Medicaid members on all MCO denials. | Plain language explanations of authorization denials and reductions is a federal requirement and monitored on a regular basis as well as part of the MCO external quality review. |
| Recommendation: Require that all MCO provider manuals be clearly posted in an easily accessible format and location on the MCO's websites and available in hardcopy. | All provider materials for each MCO is posted on their websites as well as centralized on the Medicaid Modernization webpage at: https://dhs.iowa.gov/iahealthlink/resources/provider-specific. |

**Medical Assistance Advisory Council (MAAC)**
**Medication Approval and HCBS Recommendations**
**June 27, 2017**

| Recommendation/Referral | Response |
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| Recommendation: Enforce regulation that Managed Care Organizations (MCOs) follow established stated Preferred Drug List (PDL), as required within their contracts. | The Department enforces the contract requirement that the MCOs follow the state PDL when it is brought to the attention of the Department that this has not occurred. Contract requirements are enforced through a spectrum of remedies from written warnings to corrective action to termination of the contract. To date, the Department is not aware of systemic issues with the MCOs following the state PDL. Rather, the Department has worked with the MCOs on a case by case corrective action where the state PDL appears to be misunderstood or incorrectly programmed. |
| Recommendation: Encourage the MCOs provide data regarding medication denial rates for MAAC Executive Committee to monitor for future recommendations. | The MCOs provide data on the top reasons for pharmacy denials and this is provided in the managed care quarterly performance reports. The Department is analyzing pharmacy encounter data, provided by the MCOs, for trends in approval and denial by drug type and reasons for denial. |
| Recommendation: Extend the allotted 30 day nursing facility stay for HCBS Waiver recipients to 120 days. | The Department of Human Services has promulgated rules to change this policy from 30 days to 120 days. |